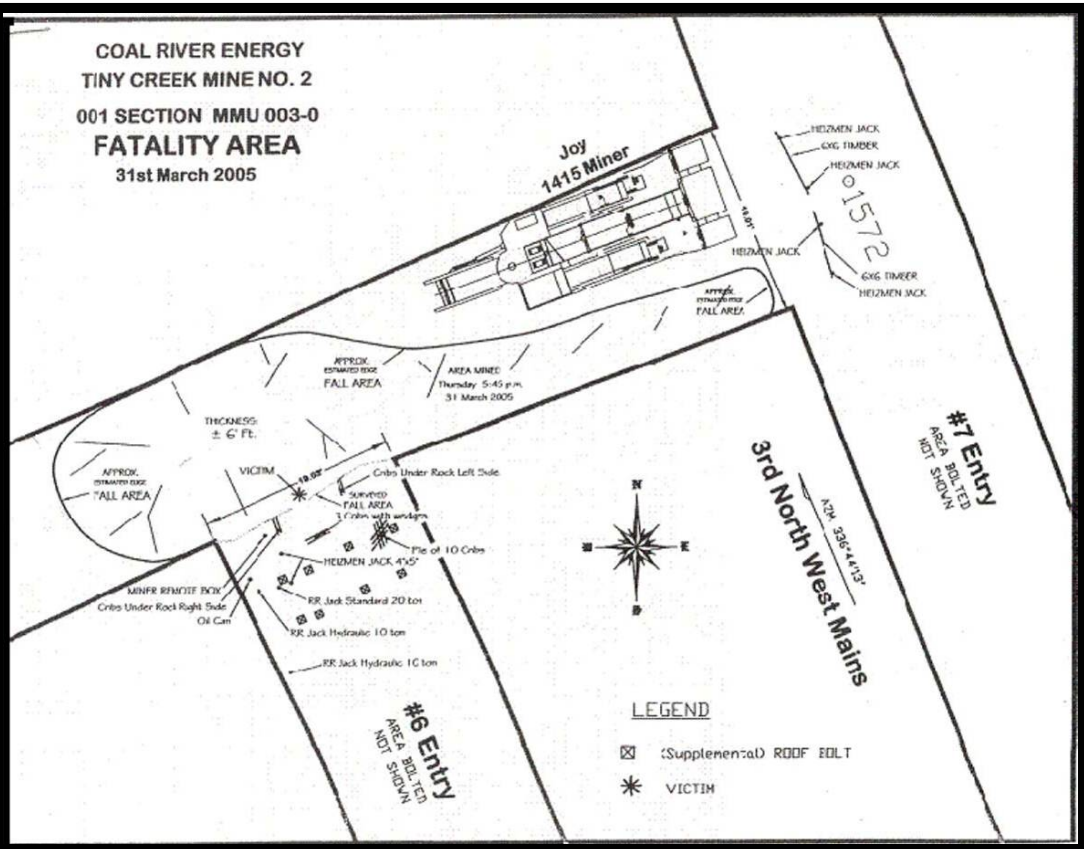
*This presentation is for illustrative and **general** educational purposes only and is not intended to substitute for the official MSHA Investigation Report analysis nor is it intended to provide the sole foundation, if any, for any related enforcement actions.*

GENERAL INFORMATION

Coal Mine Fatal Accident 2005-03

Operator:	Coal River Mining, L.L.C.
Mine:	Tiny Creek No. 2 Mine
Accident Date:	March 31, 2005
Classification:	Roof Fall
Location:	District 4, Lincoln County, West Virginia
Mine Type:	Underground

ACCIDENT DESCRIPTION



A 49 year-old cont. mining machine operator, with 28 yrs of mining experience, started mining in the crosscut between the No.'s 5 and 6 entries and continued mining to the no. 7 entry intersection, a cut distance of approx. 68 feet. Upon completion of the cut, the victim was positioned between the 1st and 2nd row of permanent roof support in the no. 6 entry. The unsupported roof in the intersection of the no. 6 right crosscut fell, overriding the 1st row of roof bolts, catching the victim near the edge of the fall and causing fatal injuries.

ROOT CAUSE ANALYSIS

Causal Factor: The approved roof control plan was not being complied with on the 3 Northwest Mains section. An extended cut was mined from the number 5 right crosscut at survey station number 1574 through the number 6 entry and continued through the number 6 right crosscut to the number 7 entry, a distance of approximately sixty-eight (68) feet. The continuous mining machine operator was positioned inby the 2nd full row of roof bolts while mining a deep cut in the number 6 right crosscut. The depth of the cut from the number 5 right crosscut to the number 7 entry was not reduced where loose, broken roof was present and not cut down. Reflective devices were not installed on the second full row of roof bolts outby the face. During an accident investigation, reflectors were observed on the 5th row of bolts outby the faces of the number 5 right crosscut and the No. 6 entry.

Corrective Action: All underground miners received extensive roof control re-training on April 14, 2005. The approved roof control plan was revised to require the section foreman to authorize any cuts that exceed 20 ft.

ROOT CAUSE ANALYSIS Cont'd.

Causal Factor: The number 6 right crosscut was started from an area that was not supported, in violation of the approved roof control plan. The crosscut was mined from the adjacent number 5 right crosscut and the number 6 entry face was not fully roof bolted.

Corrective Action: All underground miners received extensive roof control re-training on April 14, 2005.

CONCLUSION

The accident occurred because the approved roof control plan was not being followed when an extended cut was mined from the number 5 right crosscut, across the number 6 entry, through the number 6 right crosscut and into the number 7 entry. The victim was positioned in violation of the approved roof control plan between the last and next-to-last row of permanent roof support.

ENFORCEMENT ACTIONS

A 104(a) Citation was issued for a violation of 75.220(a)(1).

The approved roof control plan was not being complied with in that an extended cut was mined from the no. 5 crosscut right at survey station no. 1574 through the no. 6 entry and continued through the no. 6 right crosscut to the no. 7 entry, a distance of approximately sixty-eight (68) feet. Drawing No. 2, Page 9 of the approved roof control plan limits deep cuts to forty (40) feet in depth. The continuous mining machine operator was positioned inby the 2nd full row of roof bolts while mining a deep cut in the no. 6 right crosscut. Drawing no. 2, statement no. 9, Page 9 of the approved roof control plan prohibits persons from advancing inby the next to the last full row of permanent supports except to install temporary or permanent supports. The depth of the cut from the no. 5 right crosscut to the no. 7 entry was not reduced where loose, broken roof was present and not cut down. Statement no. 11, Page 5 of the approved roof control plan requires that where loose, drummy, or broken roof is encountered and not cut down, the depth of the cut will be reduced to effectively control the mine roof. Reflective devices were not installed on the second full row of roof bolts outby the face. During an accident investigation, reflectors were observed on the 5th row of bolts outby the faces of the no. 5 crosscut and the no. 6 entry.

ENFORCEMENT ACTIONS Cont'd.

A 104(a) Citation No. 7234308 was for a violation of 75.203(c).

The number 6 right crosscut was started from an area that was not supported according to the approved roof control plan. The crosscut was mined from the adjacent number 5 crosscut right and the number 6 entry face was not fully roof bolted. This condition was a contributing factor to a fatal accident that occurred on March 31, 2005.

A 104(a) Citation No. 7234307 was issued for a violation of 75.202(b).

Evidence indicates that three shuttle car operators were working and traveling under unsupported roof of the 3rd North West Mains section, 003 MMU, on March 31, 2005 on the second shift. A cut was mined from the number 5 right crosscut through to the number 7 entry, a distance of approximately sixty-eight feet. The actions of the shuttle car operators facilitated the development of the 68 foot cut. This was a contributing factor to a fatal roof fall accident which occurred to the continuous miner operator on March 31, 2005.

BEST PRACTICES

- Know and follow the approved roof control plan.
- Never travel under unsupported roof.
- Never employ mining methods that result in exposing miners to the hazards of unsupported roof.
- Be alert to changing roof conditions at all times.